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'IT'S GOOD TO GO FOR A TEST'



**Final Report** of the Evaluation of Waverley Care's HIV  
Awareness Campaign in African Communities in Glasgow



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HIV Awareness Campaign in African Communities in Glasgow

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HIV Awareness Campaign in African Communities in Glasgow

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### *Ministerial Foreword*

*In a world where almost 40 million people are living with HIV, preventing the spread of the infection is critical.*

*The number of cases of HIV is rising in Scotland and we recognise that this is a challenge not only for the Scottish Government but for other statutory and voluntary organisations working alongside local communities.*

*It is both very humbling and important to have an insight into the lives of individuals, families and communities who are affected by HIV/AIDS and it is vital that everyone who lives in Scotland has access to information, education and services relevant to them whatever their ethnicity, race, nationality, colour, sexuality or HIV status.*

*Key to preventing the spread of HIV in Scotland is early diagnosis and treatment. We are encouraging health care professionals to test for HIV much more routinely, particularly in settings where testing is not commonplace. Early diagnosis and treatment is vital to maintaining the health of people living with HIV and to reducing the risk to others.*

*We also have a responsibility in Scotland to challenge the stigma and discrimination that is associated with HIV. While we recognise that attitudes can not be changed overnight, this will be a focus of our work for the foreseeable future with the learning from this report helping to develop our policy on HIV for the future. We also hope to continue dialogue with African Communities, via agencies such as Waverley Care, to ensure that the particular issues affecting them are considered as part of this work.*

*I would like to pay tribute to the hard work of those who have contributed to this evaluation, especially those from the African Community living within Scotland. I shall ensure that we continue our strong links with Waverley Care and other voluntary sector organisations who have expertise in this area and that we support them to continue their excellent work with local communities which reaches out to those who need it most.*

Shona Robison



# Section 1: Setting the Scene

HIV Awareness Campaign in African Communities in Glasgow

## 1.1 INTRODUCTION

This report presents findings of the evaluation of Waverley Care's HIV Awareness campaign which was targeted at African communities in Glasgow in the later months of 2007. The evaluation collected information and data from interviews with key project members and advisers, a questionnaire survey, participant observation and interviews with African people.

The evaluation was conducted between June 2007 and March 2008 by a team of researchers led by Professor Vivienne Cree from the University of Edinburgh.

Section 1 of this report begins with a brief executive summary. It goes on to provide background information about the HIV Awareness Campaign and about issues facing the African community in Scotland in relation to HIV.

Section 2 describes the methodology for the evaluation.

Section 3 reports on findings from the evaluation, specifically in relation to the views of project members and advisers, GPs and African people. The greatest space is afforded to the perspectives of African people.

Section 4 concludes the report and offers recommendations.

Section 5 presents a bibliography.

## 1.2 ACKNOWLEDGEMENTS

I would first like to thank the team of researchers who contributed to the work of this evaluation: Jennifer Wallace, who worked me on a previous research project which looked at the experiences of children affected by parental HIV (Cree et al 2006); Frederick Longino and Rosemary Okoli who are Social Work PhD students at the University of Edinburgh; and Carla Nzombe who is a Social Work Masters' graduate from the University of Edinburgh.

I would like to thank the Scottish Government for funding this evaluation, and the Scottish Government and Gilead for their financial support of the HIV Awareness Campaign and the African Health Project. I would also like to thank the School of Social & Political Studies at the University of Edinburgh and the University of Edinburgh for waiving all indirect costs associated with the evaluation.

The evaluation would not have been possible without the openness, generosity and support of the African Health Project staff and advisory group members.

I would also like to express my sincere gratitude to the African people who shared their time and their insights with us.

In preparing this report, none of the statements made can be attributed to an individual, but people will recognise their own contributions to the evaluation.



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### 1.3 EXECUTIVE SUMMARY

The report presents findings of the evaluation of Waverley Care's HIV Awareness campaign which was targeted at African communities in Glasgow. The campaign was run by Waverley Care's African Health project which had opened in Glasgow in June 2006. The campaign operated during the later months of 2007 and culminated in an African evening held in December 2007.

The aim of the evaluation was 'to evaluate the planning and delivery of Waverley Care's campaign to increase HIV awareness and the benefits of early testing to the African community in Scotland'. The main focus within this was to find out what GPs, community stakeholders and African people felt about the campaign and the issues with which it was concerned. The evaluation was conducted between June 2007 and April 2008, by the University of Edinburgh.

The evaluation used a multi-method approach. Information and data were collected from interviews with key project members and advisers, a questionnaire survey completed by 99 respondents, participant observation at various events and interviews with eight African people who attended the African evening.

The evaluation found that GPs would like to have access to skills training which focuses on asking difficult questions; working through interpreters; helping people who may be frightened and stigmatised. In addition, GPs would like more knowledge and information about HIV; about HIV and African people; and about cultural differences. Finally, the evaluation points to the need for health service managers to think more about organisational constraints including lack of time to spend with patients, uneven numbers of African patients (some have none) and access to interpreters.

No independent contact was made by the researcher to community groups, although community stakeholders contributed their views to the questionnaire and interviews. The project worker's approach was to work in an organic way, starting with conversations with people in 'ones and twos'. Eight African people from different backgrounds were trained as volunteers and engaged as 'conduits' to community groups. Formal inputs were given to a range of groups including country associations, a football club and a church service.

The survey and interviews provided highly-detailed feedback about African people's views about HIV testing and about the HIV awareness campaign.



#### Engaging with African people – what works best?

- Although flyers and posters are useful, as are formal inputs to training events, it was word of mouth, and, more particularly, the invitation of someone regarded as a friend which was most important to African people.
- African people enjoy events which mix education with music, dancing and food. They would like to see more of this kind of event in the future.
- There were relatively low levels of knowledge and awareness about the African Health Project and Waverley Care in general amongst those who took part in the survey and interviews. Those who had accessed Waverley Care's services spoke very highly of them.

#### Informing African people about HIV and HIV testing – what works best?

- Formal presentations about HIV at the African evening were seen as helpful.
- The accounts of the life experiences of HIV positive people were seen as particularly inspiring and encouraging.
- Some argued that the focus of future campaigns should not simply be on African people, but on the whole population, and most especially, young people. Targeting was seen as stigmatising, and it also missed the opportunity to educate everyone.
- There was little support for the idea of outreach testing, but a lot of support for free condoms being available at events in the future.

#### Views of African people about HIV-related issues?

- Those who took part in the African evening demonstrated high levels of knowledge and understanding about HIV and the importance of HIV testing.
- Just over half of those surveyed preferred to use specialist services for HIV testing. GPs were the favoured option for testing by all but one of the people who were interviewed. Not only did people prefer to go to their GPs, but informants felt that GPs should take a more active role in inviting people to be tested.
- Encouragingly, most of those who responded to the survey said that nothing would stop them going for an HIV test. Those interviewed described very varied experiences of HIV testing. One person admitted that because of fear, nothing could persuade him to go for an HIV test.

#### Views of African people about support for health issues?

- Most respondents felt that events like the African Evening are a good way of providing information to the African community.
- Others argued that the kind of support which Africans need is broad-based, not just related to HIV; that they have issues about employment, housing and income, amongst others.

The findings conclude that African people are a resource for Scotland. Their willingness to work for 'the greater good' provides a catalyst for future policy and practice.



HIV Awareness Campaign in African Communities in Glasgow

Ten recommendations lead on from the conclusions.

1. The African Evening provides a springboard to further events and action, which should continue to be African-led, bringing together a range of African people.
2. Contact should be made with a wide range of community groups, not simply those concerned with health issues.
3. All future contacts with groups and individuals need to ensure that the role and function of the African Health project and Waverley Care in general is explained fully.
4. Further work needs to be undertaken to educate Africans in Glasgow about HIV and HIV prevention. This can be done through contact with community associations and groupings.
5. Challenging fear and stigma needs to remain a priority for all future work.
6. There needs to be more training and support for GPs in Glasgow around HIV issues, especially since many will be working with relatively small numbers of HIV positive and African patients.
7. Health Scotland should explore the implications of the proposal that HIV testing should become part of routine health screening. It is also recommended that free condoms are made available at a wide range of settings in the future.
8. Future events should be organised with a mix of social and educational activities. Some events should be specifically targeted at young people.
9. HIV positive people should continue to play a key role in any future events, and in supporting people with HIV.
10. Future health education campaigns should be more broadly based and targeted at the whole population, not just African people.

## 1.4 THE HIV AWARENESS CAMPAIGN IN GLASGOW

The HIV Awareness Campaign in Glasgow was led and delivered by Waverley Care's African Health Project. The project is funded by the Scottish Government's Multiple and Complex Needs (MCN) Programme. The MCN initiative supports 14 projects, all targeted at improving service delivery across a range of areas with clients who have been identified as having 'multiple and complex needs'. A global evaluation of the overall MCN Programme is currently underway, but it was a condition of the projects' grants that each should commission its own evaluation over and above this, hence this evaluation was advertised and commissioned.

The aim of the HIV Awareness campaign, as expressed in Waverley Care's Monitoring Report of June 2006 to March 2007, was 'to address current evidence of late HIV testing amongst Africans, so to encourage people to go for an HIV test and to recognise that knowing one's HIV status is a key component in preventing transmission of HIV.' Leading on from this, its objectives were:

- To increase awareness and knowledge about HIV testing and treatments
- To increase awareness, knowledge and confidence about accessing health care in Glasgow
- To challenge the stigma and discrimination about HIV

## 1.5 TIMETABLE OF THE CAMPAIGN

The following schedule was agreed at the first planning meeting held in June 2007:

June to September 2007	Planning the campaign
October to November 2007	Rolling out the campaign
December 2007	The main event
January to February 2008	Follow-up

## 1.6 THE CONTEXT OF THE CAMPAIGN: HIV AND THE AFRICAN COMMUNITY IN SCOTLAND

The campaign, as stated above, was run by Waverley Care's African Health project. This project began in 2006, following on from the publication of a key report in 2005 on the issues faced by Africans living in Scotland who are HIV positive (Sinyemu and Baillie 2005). This report identified that HIV-positive African people in Scotland were facing a number of hardships and disadvantages. Not only did they experience discrimination and exclusion on the basis of their 'race' and ethnicity, but they suffered from additional problems associated with ill-health, HIV stigma, isolation and (at times) poor treatment from health workers. For those whose immigration status was uncertain, or who were asylum seekers, life was even more difficult, because they were not allowed to work, and were often living in inadequate housing. Sinyemu and Baillie called their report 'HIV becomes your name', reflecting the views of one person who felt that a diagnosis of HIV now dictated their lives and everything about them in the eyes of others.



#### HIV Awareness Campaign in African Communities in Glasgow

Sinyemu and Baillie's report acknowledged that needs were most pressing in Glasgow, where there was little support available for African people with HIV. (An African support worker had previously been based at Waverley Care in Edinburgh, and, as a result of this, it was felt that African people were better linked into services there.) The report also stressed the need to increase awareness of HIV amongst the African community, since most African people in the UK presented with HIV late, and, as a consequence, received an AIDS diagnosis at the same time as an HIV diagnosis. This finding mirrors earlier research which suggested that HIV-infected Africans tend to be diagnosed later than other population sub-groups (Burns et al 2001).

Waverley Care launched its African Health project in Glasgow in June 2006 in response to this report, and with the financial backing of the Scottish Government's MCN initiative. The project employed two African workers, one focused on support for individuals, and the second with a broader training and outreach remit. In interview, the project manager admitted that Waverley Care went into Glasgow 'pretty cold'; there was much to be done in networking and building relationships with existing agencies, services and groups. Frustratingly, it took nine months to get premises but an office is now located in Gartnavel Hospital in the west end of Glasgow. This provides a strong base to work from, according to the project manager, since it is also the location of one of Glasgow's two HIV testing sites, the Brownlee Centre. Much of the focus of the project's developmental work and activities over 2007 was in planning for, and delivery of, the HIV Awareness campaign.

Waverley Care's decision to open a new project and run an HIV awareness campaign targeted at African people in Glasgow is supported by government statistics on HIV prevalence. Health Protection Scotland's review of 2007 (HPS 2008) provides the most up-to-date picture of the prevalence of HIV in Scotland in general, and in Glasgow in particular. The review states that 446 newly-identified cases of HIV were reported in 2007. This is the highest annual figure since recording began in 1984 and represents a 29% increase on the 345 cases reported in 2006, and an exponentially larger number than in the 1990s, when annual diagnoses numbered between 150 and 180 (though the review does acknowledge that some of the explanation for the large increase may be attributed to the increasing trend, stemming from Scottish Government policy, of offering and recommending an HIV test to all GUM (sexual health) clinic attendees suspected of having a sexually-transmitted infection since 2003). In 2007, (as in 2006), most new cases were diagnosed in the Greater Glasgow & Clyde NHS Board area. 52% of newly-reported cases in Scotland (n=231) are presumed to have acquired their infection outside Scotland. Moreover, 62% of heterosexually-acquired cases are said to belong to people who probably acquired their infection in African countries (n=112).

This is a worrying picture, giving strong evidence for the need for an HIV awareness campaign, and one located in Glasgow. However, there is also some more optimistic news in the review. It notes

that the figure for heterosexual transmissions from African countries is significantly lower than that recorded in 2004 (138) and 2005 (131). A decline is also apparent in HIV prevalence of those from sub-Saharan Africa who are undergoing HIV testing in Scotland; numbers have declined from 12% (84 out of 716) in 2004 to 6% (48 out of 816) in 2006, suggesting that a peak in this may have already been reached.

The review provides useful information about the health needs of those with HIV in Scotland. It records that the number of HIV infected individuals in specialist care has almost doubled since 2000, from 1310 to 2536, and may increase further as new data becomes available. Approximately 71% of those receiving care were on triple therapy or higher. There was a reported decrease in AIDS diagnoses (n=33) and AIDS-related deaths (n=7) in 2007, the lowest recorded number since 1992. This is encouraging in terms of the knowledge that African people have, in the past, tended to present late for diagnosis. However, putting the figures together, it is evident that there are now more people living with HIV infection in Scotland than ever before. The review notes that 'with the continuing increase in the numbers of persons in specialist care and on therapy in 2007, one of Scotland's most pressing HIV challenges is to ensure that all infected persons needing treatment and care receive it'.

Findings from the Crusaid Hardship Fund in Scotland give further information about the needs of African people in Scotland. The Fund's 2007 report states that 34% of the applicants for financial support from the fund (n=834) were people from Africa, the largest single group requiring assistance at the highest level. Within this group, 515 were asylum seekers. The report goes on to observe that since asylum seekers 'are denied the right to work (they can request permission to do so after 12 months in the country), it is not surprising that they have higher levels of need than others' (2007: 8). Other research echoes the high needs of asylum-seeking African people affected by HIV. A recent National Children's Bureau report (Conway 2006) on the experiences of children in England & Wales, concludes that HIV exacerbates the situation for children and their families who live in the UK with insecure immigration status. The combination of HIV and insecure immigration intensifies issues already faced, and areas of the asylum system sometimes work against each other, placing barriers to children and families in accessing health care and support services. These findings resonate with Sinyemu and Baillie's Scottish study, and provide strong confirmation for the necessity for changes at the level of policy and practice in this area.



# Section 2: The Evaluation

HIV Awareness Campaign in African Communities in Glasgow

## 2.1 AIM OF THE EVALUATION

The aim of the evaluation, as specified in the contract (dated 25<sup>th</sup> May 2007), was ‘to evaluate the planning and delivery of Waverley Care’s campaign to increase HIV awareness and the benefits of early testing to the African community in Scotland’. The contract noted that ‘in particular, the evaluation will cover’:

- How training delivered to GPs in Glasgow was received
- How training/information to a range of community stakeholders was received
- Whether Africans in Glasgow were aware of the campaign
- Whether they felt involved in developing the campaign
- Whether the Brownlee Centre and other specialists felt involved
- Lessons to be learned
- Any recommendations to be made

This was not, however, envisaged as a formal evaluation with a fixed set of aims and objectives which would be pursued, come what may. Instead, the contract stated that the evaluation ‘will remain open to discussion with the potential to change as new facts and information come to light during the initial research’. It concluded, ‘Both parties are committed to flexibility of approach.’

The evaluation began in June 2007, and was concluded in April 2008.

## 2.2 METHODOLOGY

Evaluation has been defined in a classic US textbook as ‘the use of social research methods to systematically investigate the effectiveness of social intervention programs’ (Rossi et al 2004: 16). Beyond this, a frequent distinction is made in the research literature between ‘formative’ evaluation and ‘summative’ evaluation, where formative evaluation ‘is intended to help in the development of the programme’, while summative evaluation ‘concentrates on assessing the effects and effectiveness of the programme’ (Robson 2002: 208). Another key distinction made is between ‘outcome’ and ‘process’ evaluations, where the first measures how far the programme has met its stated goals, while the latter ‘is concerned with asking a ‘how?’ or ‘what is going on?’ question’ (op.cit.).

This evaluation was never envisaged to be a systematic investigation of effectiveness. It was closer to a formative and process evaluation than to a summative and outcome one, but this was not its only inspiration. In order to make the evaluation truly responsive and flexible, the approach adopted owed more to principles of ‘action research’ than to evaluation in any pure sense. Action research has been described as ‘a process which alternates continuously between inquiry and action’ ... ‘a developmental

spiral of practical decision-making and evaluative reflection' (Winter and Munn-Giddings 2001: 5). Using this approach, the evaluation developed alongside the campaign, as the researcher sought to respond to what was happening in the campaign. The end-result was that some of the original expectations of the evaluation were not met (for example, no contact was made by the researcher with Brownlee staff), whereas other objectives assumed greater importance as the research unfolded (for example, the views of African people became the primary focus of the study). This approach not only gave the researcher valuable insight into the campaign, but more than this, it afforded greater access to the perspectives of those who were the targets of the campaign, that is, African people.

The methodology relied on four well-established methods of data collection:

- Interviews with key project members
- Participant observation at various campaign activities
- A survey of those who attended the African Evening which marked the culmination of the campaign
- Follow-up interviews with eight African people who had attended the African Evening

#### 2.2.1 Interviews with key project members

Semi-structured interviews were conducted with the African Health project manager, the project worker, and three members of the project's Advisory Group at the beginning and end of the project. Telephone contact was also made with the Scottish Government funder to find out more about the Multiple and Complex Needs Initiative.

The initial interviews covered the following main themes:

- Aims and objectives of the HIV awareness campaign
- History of, and background to the campaign
- Structure/management/roles of those involved in the campaign
- Plans for the campaign

The final interviews similarly reviewed the themes:

- How far aims and objectives were met
- Views about what happened and didn't happen
- Ideas about what needs to happen next

The early interviews were recorded, transcribed and analysed on the basis of already-identified and emerging themes (Arksey and Knight 1999). The final interviews were more informal, and notes were taken by the researcher.





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### 2.2.2 Participant observation

Participant observation took place at a number of events during the lifetime of the campaign:

- Planning meetings of the project staff
- GP training session, August 2007, at Greater Glasgow and Clyde NHS Board's Dalian House, Glasgow
- HIV & Human Rights Conference, October 2007, at Garnavel Hospital, Glasgow
- African Evening, December 2007, at the Community Central Hall in Maryhill, Glasgow.

The event consisted of African food, music, dance and talks relating to HIV and HIV testing.

At each event, the researcher was identified as an evaluator, and mixed with participants, asking questions informally and listening to feedback. Reflective notes were taken soon after each event, and these were fed into discussion at planning meetings. Through this approach, the researcher felt very much a member of the project team, rather than an external assessor, although it should be acknowledged that 'maintaining the dual role of observer and participator is not easy' (Robson 2002: 317).

### 2.2.3 Survey

It was agreed that a self-administered questionnaire delivered at the African Evening provided the easiest and most efficient way of getting access to a large number of African people's views about HIV testing and the HIV Awareness Campaign. We wished to find out:

- How people had become aware of the event and of the hosting organisation (Waverley Care African Health Project)
- Whether or not participants had found the talks helpful and what they had learnt from the evening
- Whether or not the talks had increased participants' likelihood of considering an HIV test
- General opinions relating to HIV and where they would be likely to go for a test
- What would stop them from having an HIV test
- What the African Health project should do to raise awareness amongst the African community about health issues



The questionnaire was designed with input from all members of the planning group, and included both standardised closed questions and some open-ended questions to encourage respondents to answer as they wished (Robson 2002). Questionnaires were distributed after the information talks at the African Evening. Three research assistants (all African) and the (white) researcher were available at the event to assist informants in filling out the forms, with the aim of increasing the response rate and overcoming any literacy difficulties.

In total, 99 questionnaires were returned at the evening. The questionnaires were coded and analysed making use of SPSS (Statistical Software for the Social Sciences) (Argyrous 2005). The information which they conveyed was highly informative, as the findings will demonstrate.

#### 2.2.4 Follow-up interviews with African people

The purpose of the follow-up interviews was to find out in more detail African people's views about the questions covered in the survey. Most especially, we wanted to find out informants' personal feelings about HIV testing, and their ideas about what more could be done to encourage African people to go for an HIV test. It was felt that a one-to-one meeting with the researcher would be the best way to access people's private views (Arksey and Knight 1999). The questionnaire therefore concluded by inviting individuals to provide their contact details if they were prepared to meet the researcher for an individual interview.

In practice, although the interviews broadly followed the topics covered in the questionnaire, their format was highly variable, and was determined largely by the issues which informants wished to discuss. Some people came to interview expecting to answer questions and did so. Others had a story they wished to pass on, whatever the interview guide might be. In one case, an informant had done considerable preparation in advance of the interview, and came with a series of written statements which were then read out to the researcher. All interviews were recorded and fully transcribed and analysed. Each informant was given £20 expenses for their participation in an interview.

### **2.3 THE AFRICAN INFORMANTS**

Eight African people took part in individual interviews. Although 25 had given their names and contact details, it was only possible to contact 12 of these, because some mobile phone numbers were found to be discontinued and some email addresses did not work. This reflects the inevitable difficulties of trying to keep track of people who are not living in secure or stable conditions. Of the 12 who agreed to be interviewed, two declined the day before and another two did not appear for their scheduled interviews. This left a group of eight informants.



Although the total number of people interviewed may seem relatively small, there was surprising diversity within this group. Four of the informants were women and four were men. Six were living in Glasgow and two in Edinburgh. Unexpectedly, informants came from seven different African countries: Botswana, Burundi, the Democratic Republic of the Congo, Malawi, Rwanda, Sudan and Zimbabwe. Informants shared other personal stories with the researcher, further adding to the sense that this was a diverse group (for example, some said that they were asylum seekers; likewise, some talked about their children, here in Scotland and at home). But this information was not sought in any systematic way, and instead, the focus of the interviews was on informants' views about HIV; it was not felt necessary to further interrogate their personal backgrounds.

Diversity was also apparent in informants' views about the campaign and about HIV testing. It might have been anticipated that those who agreed to be interviewed would be already convinced of the value of HIV testing. In reality, however, each person had a very different story to tell about their views and experience of the campaign and of HIV testing. Thus although some informants knew a great deal about Waverley Care, one person's sole knowledge of Waverley Care and the campaign was based on attending the final 30 minutes of the African Evening. Likewise, informants' experience of HIV testing varied. Three informants had been tested and were HIV positive. Of the remainder, three had recently tested negative, one was waiting for the result of a test, and one said that they refused to ever consider having an HIV test. (This person's testimony is extremely useful, as will be explored further in the findings' section.)

## 2.4 ETHICAL ISSUES

A study of this nature inevitably falls into the category of research on a 'sensitive topic' (Lee 1993). HIV is a highly stigmatised illness, requiring sensitivity and carefulness on the part of researchers (Green and Sobo 2000; Cree et al 2004; Sinyemu and Baillie 2005). There are, moreover, particular challenges in doing research with African people, some of whom may not be confident in the use of English, and some who have previously experienced harsh treatment at the hands of authority figures, making them suspicious of formal interviews (Robinson and Segrott 2002). The evaluation proposals and methodology were scrutinised and subsequently approved by the University of Edinburgh's School of Social & Political Studies Research Ethics Committee.

Care was taken to ensure that informed consent was achieved on the part of those completing the questionnaires and taking part in the interviews. This was achieved at the African Evening by having three African research assistants present throughout the event (along with the white researcher) to help with the questionnaires and answer questions. Subsequent to this, all those who had given their contact details were phoned or emailed by the researcher. Letters were sent out to all those who agreed to be interviewed explaining the areas which would be covered in the interviews.

Informants were given the opportunity to decline an interview by a 'reminder' phone-call 24 hours before the interview. At the beginning of the interview, informants were asked for their agreement for the discussion to be recorded, and at the end, leaflets were made available to those who wished to speak to someone else or to find out more about the African Health Project. Informants all retained full contact details of the researcher, and were invited to attend the launch of the evaluation report.

One person emailed the researcher in some distress in the period between first contact being made and the interview being scheduled. In response to this, the researcher asked for permission to pass on details to the African Health Project, and the person agreed. The researcher did so and the project worker followed this up immediately.



# Section 3: Findings from the Evaluation

HIV Awareness Campaign in African Communities in Glasgow

## 3.1 VIEWS OF PROJECT MEMBERS AND ADVISERS

In anticipating what the HIV Awareness campaign might achieve, the project manager's aspirations were measured. She was clear that it was still 'quite early days' for the African Health project in Glasgow; much work still had to be done in making contact with community groups and, especially, country associations. She saw the targets of the campaign not just those living with HIV, but Africans generally. In other words, her priorities were focused on prevention messages and trying to do something to encourage people to come forward for testing. But she was aware that although the programme may look quite an ambitious one, it was important to 'keep it simple'. She advised that it would only work if it used 'a gentle and respectful approach', because, as she said, 'respect is still so much part of the African culture':

'So it's about finding ways of saying to people, actually this is for your benefit you know, this is information that you may use or not use but it feels important that you have the information to make choices.'

The idea of having a campaign which culminated in a social event – a 'gathering' – was also very much part of what was perceived to be an African tradition. The project manager explained that a service user had first asked her to run an event which included theatre or dancing along with the dissemination of information. This is a familiar process in parts of Africa, and the HIV African Policy Network has been building on this approach in their work in London.

In reviewing the campaign's achievements, the project manager said that she thought that probably too much had been expected in too short a time. In practice, the action had centred on an event (the African Evening), rather than a campaign as such. However, thanks to the success of the African Evening, the campaign proper could now begin, because so many links had now been established with community groups and African people in Glasgow, and such goodwill had been generated. Other project advisers agreed that the evening had provided a good basis to follow on with, 'a launch-pad for future work', said one. The survey, and the subsequent interviews, had also provided very practical information about how best to engage with African people in Glasgow.

## 3.2 VIEWS OF GPs

On the advice of the project manager, it was decided not to make a formal approach to GPs in Glasgow during the course of the evaluation. Instead, the researcher attended a training event organised by the Glasgow Health Board at which there was a substantive input by the African Health Project worker, and this gave an opportunity for observation and for gathering feedback on some of the issues facing GPs.

Thirty-six GPs registered in advance for the late afternoon/early evening training session. Disappointingly, only 20 attended. The African Health Project worker gave an input in which he

stressed that for many African people, the GP is their first point of contact, yet this can often be a missed opportunity, either because patients do not present with obvious symptoms, or because the GP does not ask about HIV. He suggested that many GPs think HIV is a 'specialist' conversation, requiring 'specialist' skills; this, he argued, needs to change. The session was ranked highly by those who attended. Of the 12 people who completed evaluation forms, eight agreed that the session had changed the way they would provide services towards African people in the future. Most said that the session had encouraged them to invite patients to have HIV tests, and they recognised the need for a more flexible approach to patients on their part.

At the session, the project worker invited GPs to write down three personal and organisational challenges which they face in engaging African people on HIV issues within their clinics, and he then engaged in an open 'question and answer' discussion with them concerning the issues identified.

The personal challenges identified included:

- 'Hesitation about raising issues' – not wishing to seem discriminatory or prejudiced – 'not wanting to cause offence'.
- Stigma around HIV in the community may lead people 'to perceive a question about HIV as racist'.
- 'Lack of knowledge about epidemiology' and 'lack of knowledge of the degree of risk in my African patients'.
- Symptoms may or may not suggest a diagnosis of HIV – patients 'tend to present with non-specific problems'. 'Need to tune into different presentations'.
- 'Patients are frightened to be tested as they think this may affect their immigration status'.
- 'Language barriers – some French-speaking patients'; also body language, verbal and written language may be very different, and 'people may have different beliefs about illness and infection'.
- 'Limited knowledge of cultures' - Africa is a huge continent – 'some background knowledge may be necessary'.
- Gender and power issues – people can seem 'passive'; they are afraid to ask questions and seem diffident; 'women may blame themselves'. 'The more polite the patient, the more difficult it is to raise in time'.
- 'Communicating bad news' is difficult. It is difficult too 'to raise questions relating to risk activity' with people.

Organisational challenges included:

- Time – there may be 'several complex health issues to discuss at one GP visit'. 'Not enough time'. A 10-minute consultation is not enough'.
- 'Time-keeping may or may not be a priority to African people – 'they expect to be treated whenever they arrive'.
- There are a few pockets of people living in isolated areas. 'I have NO African patients'.
- Language – difficulties in getting access to interpreters.
- High drop-out rate on the part of African patients – 'people come and go all the time' – they 'move areas and records arrive late. Can make it difficult to build up a relationship with a GP'.



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- Acknowledgement that offices may not feel like safe places for African people to come.
- 'Confidentiality and secrecy in an African context means just that - professional sharing of information is not expected'. So an African patient who meets one GP may not want to be seen by someone else, and will not expect their personal information to be shared with anyone else.
- How to give priority to this work when employers seem not to value this work.

The challenges shared by GPs in this session provide valuable insight into the personal and institutional difficulties which they face in supporting African patients. Taken together, they suggest three ways forward. Firstly, they suggest that GPs would appreciate access to skills training which focuses on asking difficult questions; working through interpreters; helping people who may be frightened and stigmatised. In addition, GPs would like more knowledge and information about HIV; about HIV and African people; and about cultural differences. Finally, the feedback points to the need for health service managers to think more about organisational constraints including time, numbers of African patients and access to interpreters.

Many of these issues were also reflected in the interviews with African people. All those interviewed (as will be described more fully later) saw the GP as the central person in their health care, and none felt it would be inappropriate for the GP to invite them to have an HIV test, as long as it was asked sensitively. Those who had HIV all described the shock they felt in finding themselves HIV positive; their symptoms had either been non-existent, or they had not known them to be HIV-related. For example, when Informant D was told she had HIV, she refused to believe this, and insisted on being tested again and then again. Informant H also had no idea she had HIV. She described this vividly:

'If I hadn't been in agony, I'd probably have said, 'Not now' if someone had asked me to go for a test. But I've seen it – yes! I didn't have TB or malaria. All I had was stomach pains and bleeding that wouldn't stop. I was – what? Me? Oh dear.'

Although the session with GPs was appreciated by those who attended, it is unclear how far the project worker was speaking to those who were already sympathetic to the subject. Earlier research had observed that GPs, while central in African people's lives, were not always found to be supportive (Sinyemu and Baillie 2005). Given the findings from the survey and the interviews with informants which demonstrate the importance given to GPs by African people, it is clear that much more needs to be done to engage with GPs in the future, whether or not they are already attuned to HIV issues.

### 3.3 VIEWS OF COMMUNITY STAKEHOLDERS

No independent contact was made by the researcher to community groups, although community stakeholders did contribute their views to the questionnaire and interviews. From the researcher's point of view, it would have been impossible to make contact with community associations since so much of the campaign's activities with community groups happened in a spontaneous way in the last few weeks leading up to the African evening. This was discussed with the project worker at the end of the evaluation. He advised that the African community in Glasgow is a very diverse community, made up of a mixture of formal country associations, informal groupings and a large number of isolated groups and individuals. In response to this, his approach had been to work in an organic, developmental way, starting with conversations with people in 'ones and twos', and at the same time, engaging eight African people from different backgrounds to be trained as volunteers. They acted as conduits to community groups, and helped in various ways in planning and delivering the African evening. The project worker stressed that this approach had been essential in providing information about where people were located and in creating trust; as he said, 'the best way to get introduced was through a member of the community'. The downside, however, was that there was sometimes little opportunity for forward planning of meetings (and hence external evaluation of them), as he sought to respond quickly to opportunities when they came up.

The project worker gave formal inputs to the following country associations: the Congo group, the Brazillville group and the Rwandan group. He also addressed a meeting around World Aids Day of Afroscots Football Club, formed in 2004 with the main aim of encouraging young people into sport. (Afroscots United has African members from Algeria, Angola, Ghana, Libya, Malawi, Nigeria, South Africa, Uganda, Zambia and Zimbabwe as well as members from Asia, the Caribbean, Scotland and other backgrounds.) The project worker together with a colleague from HIV Scotland addressed a lunch-time meeting of the Glasgow Anti Racist Alliance (GARA), a multi-agency social inclusion partnership which was established in 1998 to tackle the social exclusion of young people caused by racism in Glasgow. Finally, the project worker met groups of people from Malawi, Uganda, Zimbabwe and the Gambia, and spoke to a people from Kenya and Tanzania at the end of their Sunday service held at Glasgow Caledonian University.

Looking ahead, it seems that much can be built on in future months with community groups. Health project staff plan to develop further their work with existing volunteers, at the same time as looking to recruit more in the future. Meanwhile, African people who were interviewed for the evaluation felt that the associations which they are members of would welcome contact from the project. The project worker sees maintaining momentum as a priority here, whilst working towards a time 'when communities have more ownership and involvement, so that our place becomes more advisory and facilitative'.





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### 3.4 VIEWS OF AFRICAN PEOPLE

The survey and interviews provided wide-ranging and highly-detailed feedback about African people's views about HIV testing and about the HIV awareness campaign. Findings have been drawn together and are presented here thematically. Where someone's expressed view sums up a general theme or demonstrates a particular issue, this is presented verbatim.

#### 3.4.1 Engaging with African people – what works best?

The survey demonstrated that most people heard about the African Evening through a friend (72% stated this). Although flyers and posters had been useful, as had inputs to training events, it was word of mouth, and, more particularly, the invitation of someone regarded as a friend that had brought people to the event. This leads to two important observations for future practice. Firstly, investing in formal communication tools (such as expensive posters) may not be the best way of communicating with African people. Secondly, high value is placed on friendship within the African communities; those seen as 'friends' may, in this context, include practitioners and volunteers.

The survey also showed that those who attended the African Evening did so for a range of reasons. In purely statistical terms, more people said they had come 'to listen to music' (36%) than those who had come 'to find out about HIV and HIV testing' (28%). But this is not the whole story. A more meaningful observation is that most people came for both the educational and the social aspects, and they liked the mix of formal inputs with music, dancing and food. This view was expressed in many of the interviews. For example, Informant E said: 'African people like to associate social events with serious issues: it's just the way it is!' This also reflects Waverley Care's previous experience of organising events for African people in Edinburgh (and feedback from the project manager).

All those interviewed thought that the African Evening had been a good way of getting across information about health and HIV, and many asked for more such evenings to be organised in the future. Informant E stressed how isolated African people are in Glasgow: they have few opportunities to mix with each other socially, and live quite secluded lives. Moreover, there was a sense of urgency expressed by some people, who talked about the need to keep reminding people about the messages about testing, so that they did not forget or become complacent. As Informant B asserted:

'Yes, it should be repeated. But it should be done frequently so that people don't forget. If you leave it too long, the message will be lost.'

Perhaps surprisingly, there were relatively low levels of knowledge and awareness about the African Health Project and its parent body, Waverley Care, amongst those who took part in the survey and interviews. Thirty respondents reported that they knew nothing about either the African Health Project or Waverley Care (31%). Over a third (36%) reported that they had only heard about the



African Health Project for the first time at the African Evening; others had become aware of the project only through the advertising for the event. Some people heard about the African Evening, as they said, 'by accident'; Informant F heard about it so late that he only caught the final 30 minutes of the evening. Those who knew most about the project and about Waverley Care in general had already accessed support services in Glasgow and Edinburgh, and they spoke about these services with praise and gratitude. For example, Informant G, reflecting on her own experiences of finding herself to be HIV positive, said:

'There are lots of caring people in Scotland; I couldn't get through it without them. I've been given all the support I needed – I want to thank them. You feel like a family here, with loving people...'

Likewise, Informant H, who also has HIV, attends the women's group at Solas in Edinburgh on Tuesdays. She said:

'Solas is a good place, it helps us a lot. I've got a confidence now, when I see people there – they have HIV, but they're laughing. Before, I was staying indoors, afraid to go outside, just crying, having panics, whatever – it's not easy.'

Informant D (another HIV-positive woman) had been a Body Positive member in Glasgow. This was a very important part of her life, and when the project closed down, although she has since attended the Terrence Higgins Trust (THT) project, she misses the activities that Body Positive offered. She knew nothing about the existence of the African Health Project until the African Evening, and she said she is very pleased to have heard about it, and to volunteer her services to it.

There are two important implications here. On the one hand, this demonstrates that the African Health Project and Waverley Care have much work to do in advertising their services to African people in Glasgow. More optimistically, however, since the African Evening was clearly successful in drawing the project and agency to African people's attention in Glasgow, it suggests that this can now become a springboard to further events and action. (Both points are reflected in the views of project workers and advisers.)

#### 3.4.2 Informing African people about HIV and HIV testing – what works best?

Feedback from the survey questionnaires suggested that most of those who attended the African Evening valued the formal presentations about HIV. Most said that they felt that they had learnt something new about HIV testing during the event (61%) and over a half felt that they had learnt something new about HIV services (55%). The category which achieved most responses to the question which related to 'things learnt during the talks' was 'Importance of knowing your HIV status' (14 counts). One person added: 'People should open up and be tested'. Respondents also commented on their new awareness of the need to challenge stigma associated with HIV, while others noted that they had learnt something about support organisations for those living with HIV, or about reducing their risk of HIV: 'Always use a condom', added one person.



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Many people noted that they had learnt something from hearing the life experiences of HIV positive people. One person wrote: 'Narrative accounts are so important – they affect people, make them feel and that makes them act'. When this was explored more fully in the interviews, it became apparent how impressed people had been by the shared testimonies (or as one person said, 'witnesses') of the two, HIV positive presenters. Informant C said he thought the people who spoke were so brave, that they should have statues built to them! Informant B explained this in more measured terms. He had known nothing about an HIV Awareness campaign, and had only come to the African Evening because a friend had said he wanted to go. He said:

'It was good that we had people who were affected by HIV – these people came and they talked about their lives. In this way, it encouraged people to know that, oh, you can live positively with HIV for a long time – so this was good... It helped the people to gain that confidence of living with HIV.'

However, Informant B went on to raise another important point which was also expressed by other people who were interviewed. He said that he felt that the focus of future campaigns should not simply be on African people, because everyone is at risk: 'white, black, Chinese, everyone.' He was most concerned about the behaviour of young people; he goes to clubs because he enjoys dancing (he doesn't drink or smoke) and there he sees young people putting themselves at risk. He urged that Waverley Care should try to reach young people more, for example, by organising events targeted at youth in future. Informant D took this further. She urged that health protection messages must be conveyed even earlier, through sex education in schools in Scotland. She also felt that much more could be done to make contact with churches about this matter, and she would like to see 'soaps' and films tackling issues of HIV, showing condom use and story-lines involving people who are HIV-positive. Informant E said he was frustrated that all the health messages conveyed about HIV are very negative, discouraging people from seeking help and leading to stigma. He contrasted this with other illnesses:

'There are adverts in the newspapers about breast cancer or heart conditions, and people have a general idea about what they have to do, to avoid high cholesterol and things like that. But you don't get information like that about HIV. Most of the information that you do get about HIV is very negative, and it discourages people from coming out. There needs to be more general media appeal.'

Informant C agreed. He argued that HIV information must be available everywhere:

'At university, at college, on the streets, on the buses. You should read everywhere – 'HIV: take care'... It should be everywhere, on a bus, on a train, in the newspapers, on the street.'

The idea of a new public education campaign, led by the Scottish Government, was welcomed by other informants. They felt that this would not only protect people, but at the same time reduce the stigma associated with HIV. This point was clarified further with project workers and advisers. One adviser was particularly interested in this. She said that it is widely acknowledged that ‘general health campaigns don’t work’. Yet she realised that the message coming through is that Africans don’t want to be targeted; that it is only through a general campaign that they will engage with services. This is an important finding for policy makers.

All the informants were asked whether they thought that it would have been a good idea to have HIV testing at the African Evening – should this be a feature of future events? Most people felt that this would not be appropriate. One said it might put people off coming. Another was concerned that about confidentiality; it would be difficult to hear bad news and then meet your neighbour immediately afterwards. However, one alternative suggestion was that condoms should have been freely available to all adults who attended the event. This seemed a helpful and readily-achieved proposal.

### 3.4.3 Views of African people about HIV-related issues?

Respondents were asked a range of questions to gauge their general views about HIV-related issues. Results demonstrated levels of knowledge and understanding about HIV and the importance of HIV testing that were higher than project workers had anticipated in advance (see Table 1):

Table 1: General views on issues relating to HIV

	Agree	Unsure	Disagree	Total
I know why an HIV test is important	75 (94%)	3 (4%)	2 (3%)	80 (100%)
I know why it’s a good idea to have an HIV test as early as possible	73 (92%)	6 (8%)	0	79 (100%)
I feel comfortable talking about HIV with my friends	63 (79%)	12 (15%)	5 (6%)	80 (100%)
I feel comfortable talking about HIV with my family	60 (76%)	12 (15%)	7 (9%)	79 (100%)
I know where to go for an HIV test	60 (73%)	17 (21%)	5 (6%)	82 (100%)
I feel OK about having an HIV test	58 (73%)	14 (18%)	8 (10%)	80 (100%)
I know where to go for support on HIV issues	48 (61%)	25 (32%)	6 (8%)	79 (100%)

The findings are encouraging. Not only did people know why an HIV test is important, but they said that they knew where to go for a test and felt comfortable about talking about HIV. Those who were interviewed similarly had a good understanding about issues relating to HIV. Informant G has HIV. She was articulate about the reasons for having an HIV test:

‘People should get tested and know their situation because when they are not tested and live unknowingly, they just keep on infecting other people. Besides, there’s good medication to help you. I think people should get help before it’s too late, before they get full-blown AIDS. In



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my case, it was almost too late, although I have managed now to get my health back...I also think it's good to get tested before you make your kids so that they can be safe from the virus.'

Informant H put it simply. She said: 'It's good to go for a test'. Her sister had died from AIDS in England last year because she had not sought help in time. 'Now I've got a second chance at life', she said, with great sadness.

It is difficult to make general claims about African people's knowledge about HIV from the findings from the African Evening. Because we did not try to assess levels of knowledge before and after the inputs, it is possible that the inputs themselves contributed to the high level of awareness of these issues. One person who was interviewed confirmed this; he said he had learned things he did not know about HIV treatment at the event, and that this had encouraged him to make an appointment to be tested. In a follow-up question, almost two-thirds of participants reported that the talks had made them more likely to consider having an HIV test (63%). It is, moreover, possible that those who attended the evening were already better educated, and more able to talk about HIV than some other African people. Certainly, all those interviewed agreed that there is a lot of ignorance about HIV in the African population. In addition, they admitted how hard it is to talk about HIV with friends and with family members. Some of those who are HIV positive described how they had felt obliged to keep their illness secret from their families back in Africa, in order to protect them from worry and stigma. Another person said that she could talk to her family but not to her friends, because of fear of them discriminating against her or her child. (This echoes findings from previous research into African women's disclosure of HIV status to their family and friends, see Bungener et al 2000).

The survey sought specific information about where people would prefer to go for an HIV test. This was felt to be important in terms of future targeting of services. Table 2 outlines the responses:

Table 2: Where respondents would go for an HIV test

	Number	Percent
Sandyford Clinic	31	40
My GP	27	35
Brownlee Clinic	10	13
I don't live in Glasgow	7	9
Other	3	4
Total	78	100

Findings suggest that over half of those surveyed preferred to use specialist services, either the Sandyford Initiative, a city-centre sexual health service (40%), or the infectious diseases clinic at the Brownlee Centre at Garnavel Hospital (13%). Both provide free, confidential, specialist services

which can be accessed with or without a referral from a GP, so the explanation for this preference may lie either in the anonymity of the services provided, or in their expert nature. But the reality may be less clear-cut. Over one-third of respondents said they would prefer to go to their GP. Moreover, we know from interviews that some people were referred on to the specialist units by their GPs, as in the case of Informant B, who was advised to go to Sandyford when he went to ask his GP for an HIV test. So it would be wrong to claim categorically that specialist services were preferred to GPs in terms of their role in HIV testing.

GPs were the favoured option for testing by all but one of the people who were interviewed. Not only did people prefer to go to their GPs, but informants felt that GPs should take a more active role in inviting people to be tested. As Informant B stated: 'Most people listen to their GPs. If a GP recommends a test, they will agree.' Informant A had been tested in 2002 when she arrived from the Democratic Republic of the Congo, and again in 2004 and again last week. She believes that it is vital that the GP raise the subject of an HIV test with his or her patients, because she argues, they are best placed to provide background information:

'I think it's a good thing for the GP to ask a person to do the test. My doctor asked me, 'if the test is positive, do you have someone you can talk to?' He also said that everything would be normal, if I needed treatment or anything. So they give you really important information before testing someone.'

Later in the interview, she elaborated further, outlining what she sees as the GPs responsibility in supporting people who are HIV positive:

'The GP will be like your father and mother when you have HIV. The GP is the first person who must take care of you, because he must control all your life every day. The GP is the first person.'

This may seem like a tall order, one that few Scottish GPs would be happy to sign up to. But what is being expressed here is a cultural norm; it is about authority, not dependence. It acknowledges that the GP has the authority to give guidance as well as support. This connects well with a concern raised by GPs themselves, who said that African people sometimes seemed 'diffident', 'passive', and 'afraid to ask questions'. It suggests that GPs must take the lead, and not be afraid to raise difficult issues about HIV or sexual behaviours with African patients. It also, however, suggests that African people may need help in becoming more assertive, in asking for the services that they need and want.

The survey also interrogated what people felt might prevent them from going for an HIV test. The most common response was that nothing would stop them (57%). Following that, over one in five people felt that the fear of finding out that they are HIV positive and the stigma associated with HIV would put them off being tested. Practical obstacles such as cost of travel and childcare featured in only a small number of responses (see Table 3):



Table 3: What would stop you from going for an HIV test

	Number	Percent
Nothing would stop me	42	57
Fear of finding out that I am HIV positive	17	23
Stigma	15	20
Cost of travel	4	5
Child care	2	3
Other	2	2

\*Respondents could tick more than one answer

\*\* Total responses for this question = 74

As stated earlier, those who were interviewed described very different experiences of HIV testing. Three had been tested and were HIV positive. Three had recently tested negative and one was waiting for the result of a test. Informant C said that nothing could persuade him to go for an HIV test. His explanation was passionate; he had thought long and hard about the issues. He explained:

‘To have a test is really daunting – because – ah! – the HIV is not the problem; that I learnt from the people who’ve got it. It’s a problem after HIV, when you’re positive – how you deal with this psychologically. This is what kills people, not the HIV. How they feel after is much worse than the HIV... the psychological damage is much worse than the physical damage.’

Informant C’s fear was partly about stigma – about what other people would think – but it was also a deep-seated fear about how he himself would feel, so much so that he felt it was better not to know, and simply to educate himself about what he needed to do to protect himself and his loved one sexually. He said that he could not talk to anyone about HIV, not even his GP, but at the end of the interview, said that he would try to overcome his fear and go for a test.

#### 3.4.4 Views of African people about support for health issues?

Survey respondents were asked two questions, one open and one closed, about what might help to support the African community on health issues. Over two-thirds of respondents felt that events like the African Evening are a good way of providing information to the African community. A confidential helpline and through community groups were also popular responses. Just under a third of respondents felt that a website or an information leaflet would be useful methods of providing information. The idea of a poster campaign received the least support, although a quarter of respondents would welcome this.

The open question asked respondents what else could be done to support the African community on health related issues. The most common responses related to organising more events such as the African Night. Some respondents used the opportunity to suggest that the events have more



detail or focus on young people: 'Tackle the teenagers/youth. Have social groups/events like this one and tell them about HIV.' One respondent also noted the importance of these events being free for the participants: 'More African free events because of financial restrictions.' The next most common response was that there should be more effort made to raise awareness amongst the African community (8): 'Create awareness. Some Africans in Scotland have no idea what is going on.' A small number of respondents (4) felt that more could be done to raise awareness amongst professionals and politicians: 'Get in touch with local MPs'. Two individuals responded that people from the African community should be trained and employed to provide health messages.

The interviews again provided more insight. Whilst some informants thought that a confidential helpline was a good idea, others pointed out that the cost of making calls from mobile phones was likely to be prohibitive. Furthermore, two people advised that a service like this would need to come at a second stage, after people had received basic information about HIV: what it is and how it can be prevented. Informant E had his own well-developed ideas. He proposed that Waverley Care needs to be involved in as many social and community-based events as it can, including those connected with sport, football and popular music:

'As soon as they hear there's to be a social gathering or some kind of community event that involves African people, they need to go there, not necessarily to always make speeches, but just to attend and to spread some information, some leaflets.'

He argued that the kind of support which Africans need is broad-based, not just related to HIV; that they have issues about employment, housing and income, amongst others. He talked about the 'tight-knit families' at home in Africa, and about the social isolation experienced here in Scotland, and he urged that more African health care staff be appointed, since they are more likely to understand some of the issues being faced by African people.

#### 3.4.5 Final reflections

Looking back over the contents of the findings as a whole, some final reflections must be offered. Whilst some of the language in the evaluation has been expressed in terms of the 'needs' of African people in Glasgow, the overwhelming impression which came across at the African Evening, in the survey responses and in the interviews was how much the African people of Glasgow wish to give: give to their community and give to Scotland. The project manager in a final interview said how impressed she had been with how much Africans wish to take ownership:

'... it's about the greater good, for the African community, and for Scotland. People may have great support needs, but they rarely complain ... they are a resource for Scotland.'

This was clearly evident in the interviews with African people, three of whom volunteered to work with the African Health Project in the future. A fourth is already a volunteer with the British Red Cross and a 'healthy foods' project in Glasgow. Some informants shared their concerns about Scotland and the Scottish people, and urged that future HIV campaigns must be targeted at all, not just African people, and most particularly at the risky behaviour of young people. It is this willingness to work for 'the greater good' which should provide the spring-board for future policy and practice.



# Section 4: Conclusions and Recommendations

HIV Awareness Campaign in African Communities in Glasgow

## 4.1 CONCLUSIONS

### Reaching African people

1. The African Evening was successful in drawing Waverley Care's African Health project to the attention of over 100 African people in Glasgow, from across a range of genders, ages and country backgrounds. People appreciated that this was an African event, led by a mixed group of African people.
2. The kind of support which Africans need is broad-based, not just related to HIV; they also have issues about employment, housing, income, social isolation and discrimination.
3. Most people who took part in the evaluation had heard about the African Evening through a personal contact, often described as a friend. Only half of those surveyed had heard of either the African Health project or its parent body, Waverley Care, suggesting that levels of awareness about both are rather low.

### Knowledge about HIV and HIV testing

4. Those who took part in the survey and the interviews already knew a considerable amount about HIV and HIV prevention. Such levels of knowledge cannot, of course, be assumed of all Africans in Glasgow, because it seems reasonable to suggest that those most likely to take part were also those who were already knowledgeable.
5. It was clear that in this study at least, fear and stigma played a greater part in the decision not to be tested than ignorance or lack of knowledge about HIV.

### Going for an HIV test

6. The study showed that African people would be as likely to go to their GP for an HIV test as to either of the specialist clinics. Those who preferred to access their GPs saw them as the central person in terms of delivery of health services; specialist clinics were welcomed by others as offering more expert, confidential help.
7. There was little support for HIV testing in outreach settings such as at community events. This was seen as too exposing and not offering sufficient privacy. There was, however, support for a change in practice towards more routine screening for HIV, as part of a general health screening for men and women in Scotland. Such a policy shift would see everyone's blood checked routinely at regular intervals.

### Educating African people about HIV and HIV testing

8. Those who attended the African Evening liked the mix of social and educational activities at the African Evening, and urged that more similar evenings should be held.



9. The testimonies of HIV positive people were particularly appreciated, giving confidence to others about being tested and about living with HIV.
10. There was overwhelming support for a public education campaign, led by the Scottish Government, which would make use of advertisements in all public places and target young people through sex education in schools. This would not only protect people but at the same time reduce the stigma associated with HIV.

## 4.2 RECOMMENDATIONS

### Reaching African people

11. The African Evening provides a springboard to further events and action, which should continue to be African-led, bringing together a range of African people.
12. Contact should be made with a wide range of community groups, not simply those concerned with health issues.
13. All future contacts with groups and individuals need to ensure that the role and function of the African Health project and Waverley Care in general is explained fully.

### Knowledge about HIV and HIV testing

14. Further work needs to be undertaken to educate Africans in Glasgow about HIV and HIV prevention. This can be done through contact with community associations and groupings.
15. Challenging fear and stigma needs to remain a priority for all future work.

### Going for an HIV test

16. There needs to be more training and support for GPs in Glasgow around HIV issues, especially since many will be working with relatively small numbers of HIV positive and African patients.
17. Health Scotland should explore the implications of the proposal that HIV testing should become part of routine health screening. It is also recommended that free condoms are made available at a wide range of settings in the future.

### Educating African people about HIV and HIV testing

18. Future events should be organised with a mix of social and educational activities. Some events should be specifically targeted at young people.
19. HIV positive people should continue to play a key role in any future events, and in supporting people with HIV.
20. Future health education campaigns should be more broadly based and targeted at the whole population, not just African people.



# Section 5: References

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